The Garden Surgery

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Garden Surgery on 5 April 2016. Overall the practice is rated as good for providing safe, effective, caring, responsive and well-led care for all of the population groups it serves.

Our key findings across all the areas we inspected were as follows:

- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- Patients said they found it easy to make an appointment, there was continuity of care and urgent appointments were available on the same day as requested.
- Longer appointments were given to those patients who needed them.
- Information regarding the services provided by the practice was available for patients.
- The practice had good facilities and was well equipped to treat and meet the needs of patients.
- There was a complaints policy and clear information available for patients who wished to make a complaint.
- The practice sought patient views how improvements could be made to the service, through the use of patient surveys, the NHS Friends and Family Test and the patient participation group.
- Risks to patients were assessed and well managed. There were good governance arrangements and appropriate policies in place.
- The practice was aware of and complied with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.)

Summary of findings

- There was a culture of openness and honesty, which was reflected in the approach to safety. All staff were encouraged and supported to record any incidents using the electronic reporting system. There was evidence of good investigation, learning and sharing mechanisms in place.
- There was a clear leadership structure and a stable workforce in place. Staff were aware of their roles and responsibilities and told us the GPs and manager were accessible and supportive.
- The practice ethos was to deliver good quality patient-centred care.

We saw two areas of outstanding practice:

- The practice employed their own pharmacist to assist with medication reviews, medicine optimisation and audits.
- The practice contracted the services of an independent consultant who periodically reviewed clinical performance data and reports to support improvements in service delivery and patient care

However, there was one area where the provider should make an improvement:

- The practice needs to reduce the probability of accidental interruption of the electrical supply to vaccine fridges.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- Risks to patients were assessed and well managed
- There was a nominated lead and comprehensive systems were in place for reporting, recording and investigating significant events. Lessons were shared to ensure action was taken to improve safety in the practice. All staff were encouraged and supported to record any incidents using the electronic reporting system.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions taken to improve processes to prevent the same thing happening again.
- There was a nominated lead for safeguarding children and adults. There were clearly defined systems in place to keep patients and staff safeguarded from abuse.
- There were processes in place for safe medicines management. However, the practice needs to reduce the probability of accidental interruption of the electrical supply to vaccine fridges.
- There were systems in place for checking that equipment was tested, calibrated and fit for purpose.
- There was a nominated lead for infection prevention and control.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were at or above average compared to both local and national figures.
- The practice had contracted the services of an independent consultant who periodically reviewed clinical performance data and reports to support improvements in service delivery and patient care .
- Staff had the skills, knowledge and experience to deliver effective care and treatment. They assessed the need of patients and delivered care in line with current evidence based guidance.
- Weekly clinical meetings were held between the GPs and nursing staff to discuss patient care and complex cases.

Summary of findings

- Staff worked with other health and social care professionals, such as the community matron, district nursing, health visiting and local neighbourhood teams, to meet the range and complexity of people's needs.
- Clinical audits were undertaken and could demonstrate quality improvement.
- There was evidence of appraisals and personal development plans for all staff,

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the National GP patient survey showed that patients' ratings of the practice were comparable to other local practices.
- Patients we spoke with and comments we received were positive about the care and service the practice provided. They told us they were treated with compassion, dignity and respect and were involved in decisions about their care and treatment.
- The practice had a strong patient-centred culture and we observed that staff treated patients with kindness, respect and maintained confidentiality.
- Information for patients about the services available was easy to understand and accessible.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Leeds South and East Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, the employment of a practice based pharmacist to support medicines management and patient medication reviews.
- The majority of patients said they found it easy to make an appointment, there was continuity of care and urgent appointments/access was available on the day of request.
- There was a policy in place to use a GP locum if the waiting time for non-urgent appointments was over two weeks.
- The practice operated a daily telephone triage service.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was an accessible complaints system. Evidence showed the practice responded quickly to issues raised and learning was shared with staff. Learning from complaints was shared with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were aware of their responsibilities in relation to this.
- There was a clear leadership structure in place. GPs had practice lead roles for specific areas, for example clinical governance, clinical training, safeguarding, commissioning and long term condition management.
- There were governance arrangements which included monitoring and improving quality, identification of risk, policies and procedures to minimise risk and support delivery of quality care.
- The provider was aware of and complied with the requirements of the duty of candour. There was a culture of openness and honesty, which was reflected in the approach to safety. All staff were encouraged and supported to record any incidents using the electronic reporting system. There was evidence of good investigation, learning and sharing mechanisms in place.
- There were systems in place for being aware of notifiable safety incidents and ensuring this information was shared with staff and appropriate action taken.
- The practice proactively sought feedback from patients and staff, which it acted on. There was an active patient participation group.
- There was a strong focus on continuous learning and improvement at all levels.
- The practice could evidence a good understanding of their strengths, weaknesses, opportunities and threats.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people.

- The practice provided proactive, responsive and person-centred care to meet the needs of the older people in its population. Home visits and urgent appointments were available for those patients in need.
- The practice worked closely with other health and social care professionals, such as the district nursing and local neighbourhood teams, to ensure housebound patients received the care and support they needed.
- Care plans were in place for those patients who were considered to have a high risk of an unplanned hospital admission.
- Health checks were offered for all patients over the age of 75 who had not seen a clinician in the previous 12 months.
- Named GPs attended on a weekly basis at three local residential nursing/care homes, where they had registered patients, to provide care, support and medication reviews.
- The practice participated in the End of Life project in conjunction with a local hospice, to manage patients who were not expected to live beyond two weeks and had no reversible conditions. The project provided a homely setting for patients and families to prepare for end of life in a 'home from home' environment.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

- All these patients had a named GP and a structured annual review to check that their health and medicines needs were being met. The practice nurses had lead roles in the management of long term conditions. A holistic review was undertaken for patients who had multiple conditions, to avoid the need for several appointments.
- Patients were signposted to the Leeds Better for Me programme, which provided advice and support to improve self-management of their condition.
- Patients who were identified most at risk of hospital admission were identified as a priority.

Summary of findings

- The practice delivered care for patients using an approach called the Year of Care. This approach enabled patients to have a more active part in determining their own care and support needs in partnership with clinicians and a pharmacist. It was used with all patients who had diabetes, asthma, chronic obstructive pulmonary disease (a disease of the lungs) or cardiovascular disease..
- Longer appointments and home visits were available when needed.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Patients and staff told us children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies. All children who required an urgent appointment were seen on the same day as requested.
- The practice worked with midwives, health visitors and school nurses to support the needs of this population group. For example, the provision of ante-natal, post-natal and child health surveillance clinics.
- Immunisation uptake rates were high for all standard childhood immunisations, achieving up to 100% for many vaccinations.
- Sexual health, contraceptive and cervical screening services were provided at the practice.
- 76% of eligible patients had received cervical screening, compared to 82% both locally and nationally.
- Appointments were available with both male and female GPs.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students).

- The needs of these patients had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

Summary of findings

- Telephone triage was available to assess whether the patient needed to be seen face to face or could be treated/given advice without the need for an appointment.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group. For example, early detection of chronic obstructive pulmonary disease for patients aged 40 and above who were known to be smokers or ex-smokers.
- Health checks were offered to patients aged between 40 and 74 who had not seen a GP in the last three years.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances and regularly worked with multidisciplinary teams in the case management of this population group.
- Staff knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- The practice could evidence children who were currently on a child protection plan (this is a plan which identifies how health and social care professionals will help to keep a child safe).
- There were 22 children who were on the autistic spectrum disorder and were coded on their electronic record. The practice tailored consultations to meet the needs of these children and their parents/carers.
- Information was provided on how to access various local support groups and voluntary organisations.
- As part of the blood borne virus screening programme, HIV, Hepatitis B and C testing were offered to all new patients aged between 16 and 65. Testing was also offered to those patients who were thought to be 'at risk'.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

Summary of findings

- The practice regularly worked with multidisciplinary teams in the case management of people in this population group, for example the local mental health team. Patients and/or their carer were given information on how to access various support groups and voluntary organisations, such as Carers Leeds.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.
- Advance care planning was undertaken with patients who had dementia, 75% of whom had received a face to face review of their care in the last 12 months which was comparable to the local and national averages.
- 65% of patients who had a complex mental health problem, such as schizophrenia, bipolar affective disorder and other psychoses had received an annual review in the past 12 months and had a comprehensive, agreed care plan documented in their record. This was lower than both the local and national averages.

Summary of findings

What people who use the service say

The national GP patient survey distributed 374 survey forms of which 109 were returned. This was a response rate of 29% which represented 2% of the practice patient list. The results published in January 2016 showed the practice was performing above average compared to local CCG and national averages. For example:

- 79% of respondents described their overall experience of the practice as fairly or very good (CCG 82%, national 85%)
- 63% of respondents said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG 75%, national 78%)
- 63% of respondents described their experience of making an appointment as good (CCG 70%, national 73%)
- 87% of respondents said they found the receptionists at the practice helpful (CCG 85%, national 87%)
- 97% of respondents said they had confidence and trust in the last GP they saw or spoke to (CCG 94%, national 95%)
- 97% of respondents said they had confidence and trust in the last nurse they saw or spoke to (CCG 96%, national 97%)

As part of the inspection process we asked for CQC comment cards to be completed by patients. We received 34 comment cards, the vast majority of which were positive, many describing the service and care they had received as being "very good" and citing staff as being "friendly, lovely and caring".

During the inspection we spoke with six patients of mixed age and gender, all of whom were positive about the practice. We also spoke with members of the patient participation group who informed us how the practice engaged with them. Their views and comments were also positive.

The results of the most recent NHS Friend and Family Test (March 2016) showed that 100% of respondents said they would be extremely likely or likely to recommend The Garden Surgery to friends and family if they needed care or treatment.

Areas for improvement

Action the service SHOULD take to improve

- The practice needs to reduce the probability of accidental interruption of the electrical supply to vaccine fridges.

Outstanding practice

- The practice employed their own pharmacist to assist with medication reviews, medicine optimisation and audits.
- The practice contracted the services of an independent consultant who periodically reviewed clinical performance data and reports to support improvements in service delivery and patient care

The Garden Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team comprised a CQC inspector, a GP specialist advisor and a practice manager specialist advisor.

Background to The Garden Surgery

The Garden Surgery is a member of Leeds South and East Clinical Commissioning Group (CCG) and is situated in one of the top 100 most deprived areas in Yorkshire. The Garden Surgery is located on the second floor of a purpose built health centre, which also houses a separate GP practice and various community health services. There are facilities for people with disabilities and access to the practice is via a lift or stairway. All patient areas are on the same level. There are car parking facilities available on site.

The practice has a patient list size of 5,866 with a higher than national average of patients who have a long standing health condition; 66% compared to 56% locally and 54% nationally. Approximately 79% of patients are of white British origin, with the remaining percentage made up of different ethnic origins. There are a total of 27 different languages spoken by the patient population.

There are three GP partners, two male and one female, and a salaried female GP. The practice also employs the services of a long term male GP locum, which supports the continuity of care for patients. The clinical team also consists of one advanced nurse practitioner, two practice nurses, two health care assistants and a pharmacist; all of whom are female. The clinicians are supported by a practice manager and a team of administration and reception staff.

The practice is open between 8am to 6pm Monday to Friday. GP appointments are available 8.30am to 11.30am and 3pm to 5.30pm Monday to Friday. Saturday morning appointments were available from November 2015 to March 2016 under the Winter Pressure Scheme. When the practice is closed out-of-hours services are provided by Local Care Direct, which can be accessed via the surgery telephone number or by calling the NHS 111 service.

Personal Medical Services (PMS) are provided under a contract with NHS England. The practice is registered to provide the following regulated activities; maternity and midwifery services, family planning, diagnostic and screening procedures and treatment of disease, disorder or injury. They also offer a range of enhanced services such as influenza, pneumococcal and childhood immunisations.

The practice has good working relationships with local health, social and third sector services to support provision of care for its patients. (The third sector includes a very diverse range of organisations including voluntary, community, tenants' and residents' groups.) The practice also has close links with three local residential nursing/care homes, where patients who are mainly frail elderly reside.

The Garden Surgery is a teaching and training practice and are accredited to train Foundation year doctors and trainee GPs.

We were informed both by the practice and Leeds South and East CCG of the supervision and support which had been provided by the practice to another GP practice over a period of eight months. This had resulted in additional work in the provision of clinical input for patients at that

practice and the submission of reports to NHS England. Emergency on-call and home visiting services had also been provided by The Garden Surgery over a period of six months.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations, such as Leeds South and East CCG, to share what they knew about the practice. We reviewed the latest 2014/15 data from the Quality and Outcomes Framework (QOF) and the latest national GP patient survey results (January 2016). We also reviewed policies, procedures and other relevant information the practice provided before and during the day of inspection.

We carried out an announced inspection on 5 April 2016. During our visit we:

- Spoke with a range of staff, which included two GP partners, a GP locum, the advanced nurse practitioner, a health care assistant, the practice manager and medical secretary.
- Spoke with the manager of a local residential nursing home and a community matron.
- Spoke with patients who were positive about the practice and the care they received.
- Reviewed comment cards where patients and members of the public shared their views. All comments received were positive about the staff and the service they received.
- Observed in the reception area how patients/carers/family members were treated.
- Spoke with members of the patient participation group, who informed us how well the practice engaged with them.
- Looked at templates and information the practice used to deliver patient care and treatment plans.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the Care Quality Commission (CQC) at that time. National data quoted relates to England only.

Good

Are services safe?

Our findings

Safe track record and learning

There was a comprehensive system in place for reporting, recording and investigating significant events.

- There was an open and transparent approach to safety. All staff were encouraged and supported to raise awareness of any significant events.
- Staff told us they would inform the practice manager of any incidents and complete the electronic incident recording form. The practice was also aware of their wider duty to report incidents to external bodies such as Leeds South and East Clinical Commissioning Group (CCG) and NHS England. This included the recording and reporting of notifiable incidents under the duty of candour.
- We saw evidence the practice carried out a thorough analysis of significant events. A tracking system had been developed by the practice to ensure all incidents were captured and appropriately dealt with in a timely manner.
- When there were unintended or unexpected safety incidents, we were informed patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements which reflected relevant legislation and local requirements to safeguard children and vulnerable adults from abuse. Policies were accessible to staff and clearly outlined whom to contact for further guidance if there were any concerns about a patient's welfare. The GP acted in the capacity of safeguarding lead and had been trained to the appropriate level three. We were told the GP safeguarding lead worked closely with health visitors, and although attendance at safeguarding case conferences was difficult, the practice always ensured that reports were submitted when requested. Any safeguarding concerns regarding patients were discussed at the weekly clinical meeting. Staff had received training relevant to their role and could demonstrate their understanding of safeguarding. The practice could evidence there were 18 children who were currently on a child protection plan (this is a plan which identifies how health and social care professionals will help to keep a child safe).
- A notice was displayed in the waiting room, advising patients that a chaperone was available if required. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. All staff who acted as chaperones had been trained for the role. Not all these staff had received a Disclosure and Barring Service check (DBS), however the practice assured us these checks would be undertaken. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.) It was recorded in the patient's records when a chaperone had been in attendance.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. We saw up to date cleaning schedules in place. The advanced nurse practitioner was the infection prevention and control (IPC) lead, who kept up to date with best practice. There was an IPC protocol in place and staff had received up to date training. Annual IPC audits were undertaken and we saw action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency drugs and vaccinations, kept patients safe. These included obtaining, prescribing, recording, handling, storage and security and disposal. There were three vaccine fridges located together in one room within the practice. We observed the plug of one of the fridges was easily accessible and could inadvertently be unplugged. We were assured the practice would take steps to rectify this.
- There were effective processes for handling repeat prescriptions which included the review of high risk medicines. Prescription pads and blank prescriptions were securely stored and there were systems in place to monitor their use. Regular medication audits were carried out with the support of the local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines. Patient group directions, in line

with legislation, had been adopted by the practice to allow nurses to administer medicines. Health care assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber. There were records in place identifying which medicines were kept in GPs' bags, the amounts and expiry dates.

- The practice had employed a pharmacist to support them with appropriate prescribing, medication reviews, undertaking antibiotic audits and ensuring the prescribing policy was up to date and in line with guidance. They also saw patients face to face to discuss medicines management, particularly in relation to diabetes and chronic obstructive pulmonary disease (COPD). At the time of our inspection both the advanced nurse practitioner and pharmacist were training to be independent prescribers. They received mentorship and support from the GPs for the extended role.
- We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment, in line with the practice recruitment policy. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

The practice had procedures in place for assessing, monitoring and managing risks to patient and staff safety.

- There were numerous risk assessments in place to monitor the safety of the premises, such as the control of substances hazardous to health and legionella (legionella is a term for a particular bacterium which can contaminate water systems in buildings). A health and safety policy was accessible to all staff.
- The practice had up to date fire risk assessments and carried out regular fire drills. There were designated fire marshalls within the practice. There was a fire evacuation plan in place which identified how staff could support patients with mobility problems to vacate the building.
- We were informed all electrical and clinical equipment was regularly tested and calibrated to ensure the equipment was safe to use and in good working order.
- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs. There was a rota system to ensure there was enough staff on duty. The practice had a policy to use locum GPs if the waiting time for non-urgent appointments was over two weeks.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff were up to date with fire and basic life support training.
- There was emergency equipment available, which included a defibrillator and oxygen, with pads and masks suitable for children and adults.
- Emergency medicines were stored in a secure area which was easily accessible for staff. All the medicines and equipment we checked were in date and fit for use.
- A first aid kit and accident book were available.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and was available on the practice computer system and as a hard copy. We were informed of a recent incident where the practice had used the business continuity plan effectively.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- There were systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. Updates were also discussed at GP and nursing team meetings.
- The practice monitored that these guidelines were followed through risk assessments, audits, discussion at clinical meetings and through supervision sessions.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results (2014/15) showed the practice had achieved 83% of the total number of points available, with 6% exception reporting (exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). The practice was not an outlier for any QOF (or other national) clinical targets Data showed:

- Performance for some diabetes related indicators was lower than the CCG and national averages. For example, 71% of patients on the diabetes register had a recorded foot examination completed in the preceding 12 months, compared to the CCG and national average of 88%.
- Performance for mental health related indicators was lower than the CCG and national averages. For example, 80% of patients with schizophrenia, bipolar affective disorder and other psychoses had a record of blood pressure in the preceding 12 months, compared to the CCG average of 88% and national average of 90%.

The practice informed us how they monitored QOF and also explained some of the difficulties they had with patients not attending for reviews and follow ups. They were proactive in inviting patients, chasing up non-attenders and undertaking opportunistic screening.The practice also monitored their performance against local practices through the use of reports produced by the CCG. The practice had contracted the services of an independent consultant who periodically reviewed clinical performance data and reports to support improvements in service delivery and patient care.

The practice used clinical audit, peer review, accreditation, local and national benchmarking to improve quality. There had been several clinical audits completed in the last two years, two of these were completed audits on antibiotic prescribing and blood tests on patients who were prescribed amber drugs. (Amber drugs require patients to be monitored in line with specific guidelines.) Both these audits showed improvements were made and monitored. A recent audit on asthma patients who had been prescribed more than two courses of oral steroids in the previous 12 months, had been undertaken. This had resulted in the introduction of a new yearly review template and a new method of electronic surveillance of prescribing. A date was planned for re-audit.

The practice worked closely with three local residential nursing/care homes; one of which also had 54 intermediate care beds. The majority of registered patient who were residents were frail elderly and/or had dementia. Three named GPs attended each home and undertook a weekly 'ward round' to provide care and support to patients as needed. An holistic assessment of need and the impact of increasing frailty was undertaken. All the residents who were registered with the practice had a detailed care plan in place, which included personal choice and preference regarding place of care if they were deteriorating in health. Both the practice and one of the nursing home managers verbally informed us there had been a reduction in GP call outs to the home and a reduction in unplanned hospital admissions, as a result of regular attendance by the GPs. Unfortunately, at the time of our inspection it was not possible for any written evidence to be provided.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

Good

Are services effective?

(for example, treatment is effective)

- Staff had received mandatory training that included safeguarding, fire procedures, infection prevention and control, basic life support and information governance awareness. The practice had an induction programme for newly appointed staff which also covered those topics. Staff had access to and made use of e-learning training modules and in-house training. They were also supported to attend role specific training and updates, for example long term conditions management.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for GP revalidation. All staff had received an appraisal within the last 12 months.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to online resources and discussion with other clinicians.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to clinical staff in a timely and accessible way through the practice's patient record system and their intranet system. This included risk assessments, care plans, medical records, investigation and test results. The practice could evidence how they followed up after discharge those patients who had an unplanned hospital admission or had attended accident and emergency (A&E).

Staff worked with other health and social care services to understand and meet the complexity of patients' needs and to assess and plan ongoing care and treatment. Information was shared between services, with the patient's consent, using a shared care record. We saw evidence that multidisciplinary team meetings, to discuss patients and clinical issues, took place on a quarterly basis.

Care plans were in place for those patients who had complex needs or at a high risk of an unplanned hospital admission, which were reviewed and updated as needed.

There was a good working relationship with the community matron, who informed us of the processes in place for sharing information and the joint provision of care and support of these patients.

Comprehensive care planning was in place for those patients who required palliative care and information was shared with out of hours services.

The practice had participated in a GP improvement programme (GPIP) initiative looking at how they managed test results within the practice. We saw evidence of a comprehensive flow chart system which supported staff when dealing with test results. This system ensured the risks of incidents relating to test results was minimised.

Consent to care and treatment

Staff understood the relevant consent and decision-making requirements of legislation and guidance, such as the Mental Capacity Act 2005. Patients' consent to care and treatment was sought in line with these. Consent was recorded in the patient's electronic record. Where a patient's mental capacity to provide consent was unclear, the GP or nurse assessed this and, where appropriate, recorded the outcome of the assessment.

When providing care and treatment for children 16 years or younger, assessments of capacity to consent were also carried out in line with relevant guidance, such as Gillick competency and Fraser guidelines. (These are used in medical law to decide whether a child is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services as appropriate. These included patients:

- who were in need of palliative care
- at risk of developing a long term condition
- required healthy lifestyle advice, such as dietary, smoking and alcohol cessation
- who acted in the capacity of a carer

The practice had good working relationships with local the neighbourhood team and health trainers, to support

Good

Are services effective?

(for example, treatment is effective)

patients with any additional health or social needs. Patients were referred to the Leeds Better for Me programme, which provided advice and support to improve self-management of their condition.

Patients had access to appropriate health assessments and checks. These included NHS health checks for people aged 40 to 75. Where abnormalities or risk factors were identified, appropriate follow-ups were undertaken. In addition, health checks were offered for all patients over the age of 75 who had not seen a clinician in the previous 12 months. The practice also offered blood borne virus testing for HIV, Hepatitis B and Hepatitis C, for all new patients aged between 16 and 65 and those patients who were 'at risk'.

The practice encouraged its patients to attend national screening programmes for bowel, breast and cervical cancer. There was a nominated 'practice champion' who promoted the benefits of bowel screening and followed up patients who did not attend for the screening. The uptake rates for cervical screening were 76%, compared to 82% both locally and nationally. There was a recall system in place to contact patients who did not attend for their cervical screening test. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice carried out immunisations in line with the childhood vaccination programme. Uptake rates were comparable to the national averages. For example, children aged up to 24 months ranged from 92% to 100% and for five year olds they ranged from 92% to 98%.

Patients who were concerned regarding memory loss or any dementia-like symptoms were encouraged to make an appointment with a clinician. A recognised dementia identification tool was used with the patient's consent to assess any areas of concern.

There were 22 children who were on the autistic spectrum disorder and were coded on their electronic record. The practice tailored consultations to meet the needs of these children and their parents/carers.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that:

- Members of staff were courteous and helpful to patients and treated them with dignity and respect.
- There was a private room should patients in the reception area want to discuss sensitive issues or appeared distressed.
- Curtains were provided in consulting and treatment rooms to maintain the patient's dignity during examinations, investigations and treatment.
- Doors to consulting and treatment rooms were closed during patient consultations and that we could not hear any conversations that may have been taking place.
- Chaperones were available for those patients who requested one and it was recorded in the patient's record.

During the inspection we spoke with six patients of mixed age and gender, who were positive about the practice. We also spoke with members of the patient participation group who informed us how the practice engaged with them. Their views and comments were also positive.

The vast majority of the 34 Care Quality Commission patient comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

Results from the January 2016 national GP patient survey showed respondents rated the practice comparable to the local CCG and national average to questions regarding how they were treated. For example:

- 91% of respondents said the last GP they saw or spoke to was good at listening to them (CCG 87%, national 89%)
- 93% of respondents said the last nurse they saw or spoke to was good at listening to them (CCG 92%, national 91%)
- 89% of respondents said the last GP they saw or spoke to was good at giving them enough time (CCG 85%, national 87%)
- 93% of respondents said the last nurse they saw or spoke to was good at giving them enough time (local CCG 92%, nationally 91%)
- 85% of respondents said the last GP they spoke to was good at treating them with care and concern (CCG 82%, national 85%)
- 91% of respondents said the last nurse they spoke to was good at treating them with care and concern (CCG 90%, national 91%)

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views.

The Year of Care was used with patients who had diabetes, asthma, chronic obstructive pulmonary disease or cardiovascular disease. This approached enabled patients to have a more active role, in partnership with clinicians, in determining their own care and support needs. Individualised care plans for these patients were maintained, which included health advice, how to manage an exacerbation of their symptoms and any anticipatory medicine which may be required.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were comparable to the local CCG and national averages. For example:

- 86% of respondents said the last GP they saw was good at involving them in decisions about their care (CCG 80%, national 81%)
- 83% of respondents said the last nurse they saw was good at involving them in decisions about their care (CCG 85%, national 85%)
- 91% of respondents said the last GP they saw was good at explaining tests and treatments (CCG 85%, national 86%)
- 92% of respondents said the last nurse they saw or spoke to was good at explaining tests and treatments (CCG 89%, national 90%)

The practice provided facilities to help patients be involved in decisions about their care:

Good

Are services caring?

- Interpretation services were available for patients who did not have English as a first language.
- Information leaflets were available in an easy to read format.
- The choose and book service was used with all patients as appropriate.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The patient electronic record system alerted clinicians if a patient was also a carer. The practice maintained a carers' register and offered additional support as needed. Carers were encouraged to participate in the Carers Leeds yellow card scheme. This card informs health professionals that the individual is a carer for another person and to take this into consideration should the carer become ill, has an accident or is admitted to hospital.

The practice worked jointly with palliative care and district nursing teams to ensure patients who required palliative care, and their families, were supported as needed. We were informed that if a patient had experienced a recent bereavement, they would be contacted and support offered as needed.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Leeds South and East CCG to secure improvements to services where these were identified.

- Home visits were available for patients who could not physically access the practice and were in need of medical attention.
- Urgent access appointments were available for children and patients who had a medical need which required a same day consultation.
- The practice operated a daily telephone triage service.
- Longer appointments were given to those as needed.
- Patients were able to receive travel vaccinations which were available on the NHS.
- There were disabled facilities, a hearing loop and interpretation services available.

Access to the service

The practice was open between 8am to 6pm Monday to Friday. Saturday morning appointments were available from November 2015 to March 2016 under the Winter Pressure Scheme. When the practice was closed out-of-hours services were provided by Local Care Direct, which could be accessed via the surgery telephone number or by calling the NHS 111 service.

GP appointments were available 8.30am to 11.30am and 3pm to 5.30pm Monday to Friday. Appointments could be booked up to two weeks in advance, same day appointments were available for people that needed them. Telephone consultations were sometimes held by clinicians, dependent on the need of the patient.

We were informed the practice had previously offered extended hours appointments in the evening and on Saturday, in conjunction with three other neighbouring practices. However, uptake had not been good and feedback from patients was they wanted more availability during the working week. The practice had undertaken an audit which also found the demand for appointments was highest during this time. As a result the practice had a policy in place to use a GP locum if the waiting time for non-urgent appointments was over two weeks. This was confirmed by staff we spoke with during the inspection. There were no plans to reintroduce late evening or Saturday appointments at this time, but the practice informed us they would continue to audit the availability of appointments in relation to patient demand.

Patients we spoke with on the day of inspection told us they were generally able to get appointments when they needed them.

Results from the national GP patient survey showed that satisfaction rates regarding how respondents could access care and treatment from the practice were comparable to the local CCG and national averages. For example:

- 74% of respondents were fairly or very satisfied with the practice opening hours (CCG 74%, national 75%)
- 61% of respondents said they could get through easily to the surgery by phone (CCG 69%, national 73%)
- 86% of respondents said the last appointment they got was convenient (CCG 91%, national 92%)

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- All complaints and concerns were discussed at the practice meeting.
- The practice kept a register for all written complaints.
- There was information displayed in the reception area to help patients understand the complaints system.

There had been 12 complaints in the preceding 12 months. We found they had been satisfactorily handled. Lessons were learned and action was taken to improve quality of care as a result. We saw evidence where the practice had reviewed the complaints to identify any themes or trends. For example, several complaints related to referrals to other services. Action had been taken to ensure all clinicians were fully aware of the referral processes.

Are services well-led?

Good

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. There was a statement of purpose in place which identified the practice values.

There was a strong patient-centred ethos among the practice staff and a desire to provide high quality care. This was reflected in their passion and enthusiasm when speaking to them about the practice, patients and delivery of care. The practice could evidence a good understanding of their strengths, weaknesses, opportunities and threats.

Governance arrangements

The practice had good governance processes in place which supported the delivery of good quality care and safety to patients. This ensured there was:

- A clear staffing structure and staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and available to all staff via the computer system.
- A comprehensive understanding of practice performance.
- A programme of continuous clinical and internal audit which was used to monitor quality and drive improvements.
- Robust arrangements for identifying, recording and managing risks.
- Business continuity and comprehensive succession planning was in place, for example increasing the clinical team.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour, which included communicating with patients about notifiable safety incidents. We were informed that when this happened, affected patients were given reasonable support, truthful information and a verbal and written apology.

There was a clear leadership structure in place and staff felt supported by management. Staff told us:

- There was an open and honest culture within the practice.
- The partners were approachable and always took the time to listen to all members of staff.
- There were regular team meetings where they had the opportunity to raise any issues and felt confident and supported in doing so.
- They felt respected, valued and supported, particularly by the partners in the practice.
- They were encouraged to identify opportunities to improve the service delivered by the practice.
- Learning and development was encouraged within the practice.

Seeking and acting on feedback from patients, the public and staff

The practice proactively encouraged and valued feedback from patients through the use of the patient participation group (PPG), patient surveys and any complaints or compliments they received. Feedback was also encouraged through the use of the practice website.

The PPG had six monthly face to face meetings, with virtual meetings in between as needed. They were engaged with the practice and made recommendations which were acted upon. For example, regularly displaying in reception the number of patients that did not attend appointments.

The practice also gathered feedback from staff through meetings and the appraisal process. Staff told us they would not hesitate to provide feedback and raise any concerns or issues.

There was a practice newsletter produced regularly for patients, which promoted self-care, health advice and information about services the practice provided.

Continuous improvement

Are services well-led?

Good

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

There was a strong focus on continuous learning and improvement at all levels within the practice. The Garden Surgery was a teaching and training practice. They were accredited to train Foundation year doctors and trainee GPs.

The practice team was forward thinking and part of local and national schemes to improve outcomes for patients in the area. For example, they were part of the Leeds University Action to Support Practices Implementing Research Evidence (ASPIRE) programme, which supports practice in continuous quality improvement in the delivery of patient care and sustainability.

The practice also:

- Employed their own pharmacist to assist with medication reviews, medicine optimisation and audit.
- Employed apprentice business support administrators.
- Contracted the services of an independent consultant who periodically reviewed clinical performance data and reports to support improvements in service delivery and patient care
- Participated in the End of Life project in conjunction with a local hospice, to manage patients who were not expected to live beyond two weeks and had no reversible conditions. The project provided a homely setting for patients and families to prepare for end of life in a 'home from home' environment.
- Had joined a federation of practices, which looked at how primary care services could be improved locally.
- Had signed up to a project known as ‘Deep End’, which had originated in Scotland and facilitated by the University of Glasgow. This was aimed at practices who were situated within the top 100 known areas of deprivation in order to tackle health inequalities with their patient population. At the time of our inspection, this work was only at the initial development stage.